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Yellow, in Peril: How public health discourse on tuberculosis (TB) reveals, refines, and
reinforces the racial stigmatization of Asian Americans

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**Yellow, in Peril: How public health discourse on tuberculosis (TB) reveals, refines,
and reinforces the racial stigmatization of Asian Americans**

The nurse placed her fingers over the pink spot that had formed at the site of injection on the underside of my forearm. “Positive,” she stated matter-of-factly. My heart raced. After taking a routine tuberculosis (TB) test required for my summer clinic internship, it appeared that I had tested positive for tuberculosis, the highly infectious bacterial disease that causes dangerous nodules to form in the lungs and other bodily tissues. “How could this have happened?” I asked the nurse, “Are you sure?” “Oh it’s fairly common,” she responded, and apparently having inferred my Asian background, she added, “...especially in those of Asian descent... I’ll bring in a doctor to verify the result.” While the second opinion established that I was not, in fact, TB positive, I remained intrigued and a little stunned by the nurse’s casual reference to the high incidence of tuberculosis among Asian Americans. Why did my race have anything to do with my likelihood of TB infection?

Upon further investigation, I discovered that Asian Americans are indeed reported to have higher rates of TB infection than any other racial group in the United States. According to the latest Centers for Disease Control (CDC) publication on trends in tuberculosis (TB) in the United States, in 2010, “Asians had the highest TB case rate” of any other racial/ethnic group, 25 times greater than that of non-Hispanic whites (CDC, 2010). This report notes that while overall rates of TB have decreased significantly in the United States, TB continues to be a serious threat in the Asian American community. As a student with plans to pursue a career in public health, a discipline that addresses

population-level health threats and health disparities, I sought a deeper understanding of this epidemiological phenomenon. Why do Asian Americans experience a disproportionate rate of U.S. TB infections, particularly when Caucasian TB rates have decreased dramatically? How are public health professionals approaching this issue in the United States, if at all? Is this data useful in their approaches? Have Asian Americans experienced social, political, or other structural impacts beyond the health problems associated with the disease?

In this paper, I argue that while public health discourse on tuberculosis may reveal existent epidemiological trends in and among particular social groups, the discursive framing of this data unnecessarily racializes the disease. More specifically, public health discourse uses frameworks of “othering” and an imagined transnationalism to reflect but also refine and reinforce historicized stigmas of Asian Americans as non-normative, perpetual outsiders, and disease carriers. I assert that this discursive racialization of TB superficially constructs a causal link between Asian Americans and the incidence of TB in America and consequently results in significant social and political costs for many Asian Americans. Ultimately, I propose alternative frameworks for public health discourse on TB that might more effectively address the epidemiological problem and better avoid the structural costs experienced by Asian Americans and other marginalized groups.

History of Tuberculosis in America

While some scientists suggest that tuberculosis may have existed for several millennia, the disease first became a major public health concern in the Western world in

1882 after Dr. Robert Koch famously identified the bacterium *Mycobacterium tuberculosis* as the cause. It became understood soon after this discovery that the disease, also referred to as “consumption,” was spread through the inhalation of the bacterium. Once active in the body, *M. tuberculosis* would cause dangerous and often lethal nodules or tubercles to form in the lungs and other bodily tissues. At this time, tuberculosis was a disease that directly denoted class, driving the wedge more deeply between the poor and middle to upper classes (King 2004, Rosenberg and Golden 1992). The post-industrial urbanization of the Western World in the early 20th century helped tuberculosis reach epidemic levels among the urban poor. As the lower classes often lived and worked in improperly ventilated, close-quarter environments, the bacterium had the opportunity to spread rapidly. When paired with the weakened immune systems often resulting from these stressful environments and lack of access to healthcare, the spread of TB further intensified among these populations. This urban epidemic gave rise to the advent of sanitariums as a way to deal with those infected (Rosenberg and Golden, 1992).

It was only in 1946 when effective treatment became available through the development of the antibiotic streptomycin. The worldwide epidemic was kept at bay for the decades that followed, but in the past 40 years there has been a notable TB resurgence. In the 1980s, the presence of TB reached epidemic levels in the United States due to the simultaneous emergence of HIV and drug resistant strains of the bacterium, resulting in Multidrug Resistant Tuberculosis (MDR TB). MDR TB continues to be a significant public health threat worldwide. This is true particularly in the developing world due to the lack of public health infrastructure and TB control programs. The World Health Organization (WHO) declared a TB global health emergency in 1993. Overall, the

WHO estimates that one third of the world population has been infected with TB, while notably not all infections become active cases of TB (CDC, 2010).

While rates of TB infection have significantly decreased in the US in recent years, public health reports reveal that the disease continues to be a serious threat to certain racial and ethnic minority groups, with a particular emphasis on immigrant populations. Notably, Asian Americans have higher rates of tuberculosis infection than any other racial group in the United States, followed by African Americans and Hispanics: again, 25, eight, and seven times greater than non-Hispanic whites respectively (CDC, 2010). Similarly, foreign-born immigrants have a TB infection rate 11 times greater than among U.S.-born persons (CDC, 2010). The public health community and the media have given much attention to this issue, persistently highlighting the great disparity of TB infections along ethnic, racial, and national-origin lines. In many ways, scholars argue that the field's attention to health disparities is important in formulating epidemiological and medical approaches to more effectively address the issue (Lee, S. 2004). More specifically, these reports elicit important etiological questions on which to ground public health TB control and prevention efforts in light of limited resources.

On the other hand, while the public health community and media may focus on these health disparities with the intention of improving the health status of the afflicted populations, I would like to bring into question the usefulness of framing health and health disparities in the context of race, ethnicity, and national origin. Many scholars in the social sciences suggest that this framework could result in substantial social and political costs to marginalized groups within these frameworks (Briggs 2003, Ho 2003, Lee S. 2004, King 2003). As public health reports often present social categories such as

race, ethnicity, and national origin to describe TB infection disparities without a greater socioeconomic and political context, I propose that these statistics might convey unintentional meaning to their subjects. How might these categories discursively function between and among one another to produce or reinforce perceived social identities? In my paper, I consider this question with regard to the frequent citation of Asian Americans and foreign-born persons in TB public health dialogue.

The dynamics of race, discourse, and public health

Before continuing to unpack the question of framing in public health discourse, in light of the interdisciplinary nature of my project, it is useful to define and explore the various theoretical frameworks implicit in my analytical process. The theoretical frameworks of race and racialization, discourse, and public health have developed in complex ways across a wide range of disciplines. As I bring these frameworks together in my discursive analysis, I pay close attention to the ways in which public health discourse on TB navigates processes of “othering” and an imagined transnationalism to produce and reinforce racial meaning in marginalized groups, specifically in Asian Americans.

Firstly, what does it really mean to “produce and reinforce racial meaning”? Considering the span of human history, race is a relatively new concept used to define human difference. It is important to understand that race is a “social construction,” that is, race was developed to divide people into groups based on social and/or cultural generalizations. Race is a category that is not directly related to measurable physiological, biological, or genetic differences among humans (King 2003). Intrinsic in the development of race was the development of a racial hierarchy that privileged certain

racism over others. As problematic as these categories may be in definition and operation, social scientists ironically must rely on these categories to describe social inequities and other sociocultural phenomena.

The occurrence of racial stigmatization, then, reinforces the social construction of racial categories using stereotypes, often in a way that is detrimental to the particular group in question. In other words, racial stigmatization attaches further meaning to a racial category. This process is closely related to and often amplified by another social process known as “racialization.” Foremost race scholars Omi and Winant define racialization as “the extension of racial meaning to a previously racially unclassified relationship, social practice, or group” (Omi and Winant, 1986). Racialization is a dynamic, ongoing process. Stigmatization and racialization can work in tandem to inaccurately and sometimes unjustly describe those perceived to belong to a particular racial group. Such depictions can have extremely detrimental effects on that racial group in the public sphere, potentially resulting in acts of discrimination. To combat these detrimental effects, then, it is crucial to understand the complex structures and processes involved in the production and reinforcement of racial meaning.

In exploring how public health discourse may be one such structure constructing a perceived Asian American identity, it may serve me well to contextualize what I mean when I refer to “Asian American” as a racial group. According to the U.S. census’ terms of racial categorization, the term “Asian American” encompasses all U.S. citizens or permanent residents of Asian descent. Under this racial category, there are at least 23 ethnic subgroups and at least 32 linguistic subgroups (Huff and Kline, 1999). U.S. policy, legislation, and most other public discourses including public health, consistently use this

term to describe all individuals that fall under this category. Unfortunately, the act of lumping all residents of Asian descent together into a single term generally ignores the meaningful diversity that exists within the “Asian American” category. Such an oversimplification may generate misleading conclusions about the different Asian American subgroups related to citizenship, socioeconomic status, and cultural beliefs. The relevant literature varies greatly when describing those of Asian descent (Ng *et al.*, 2007). While in my paper I would ideally like to use terms that accurately reflect these diverse experiences, for clarity’s sake I will continue to use the term “Asian American” to describe the consortium of individuals of various Asian ethnic, cultural, and linguistic backgrounds. In this way, a 4th generation Japanese, a Khmer refugee, and a 2nd generation Indonesian each would fall under the “Asian American” category.

Keeping in mind the discursive misrepresentation of the term “Asian American” as a racial category and its almost universal employment in public discourses, it is no wonder that much of the scholarship in Asian American and Ethnic studies brings Asian American stigmatization and racialization to the forefront of both historical and contemporary discussion. Asian Americans have been stigmatized as a racial group since the first waves of Chinese and Japanese immigration in the 19th century, both in terms of governmental policy as well as public perception. The American public viewed Asian migrants as the “Yellow Peril,” or economic and social threats, negatively characterizing them as outside the realm of “normal.” Additionally, local and national governments aimed to and often succeeded in heavily regulating Asian migrants through exclusionary policies. Chinese immigrants who came to work on the railroad, for example, were believed to threaten the job and wage security of white American workers and were thus

subject to overt anti-Chinese sentiment. As Asian American scholar Erica Lee notes in her 2007 essay on “Yellow Peril,” “Chinese as a race were charged with being inassimilable, inferior, and immoral.” The anti-Chinese sentiment soon amplified and changed from rhetoric to policy with the passing of the Chinese Exclusion Act in 1882, which effectively put a halt to Chinese immigration to the United States. With a newfound Chinese labor shortage, labor migration boomed from Japan, India, Korea, and the Philippines to the United States. While from distinct countries, these new immigrants essentially inherited the anti-Chinese sentiment, which generalized into anti-Asian sentiment that stigmatized and discriminated all residents of Asian ancestry. Exclusionary policies continued, such as the Gentlemen’s Agreement of 1907, which was directed against Japanese immigration, and the Immigration Act of 1924, which essentially denied immigration rights to Asians worldwide. These policies constructed all Asians as aliens ineligible to citizenship, perpetuating the public belief that Asians and Asian Americans were meant to be outsiders as they were threatening to the American way of life. Notably, in many ways, Asian American stigmas have changed over the course of the past century. Racial stereotyping and discrimination have become less and less overt, and tangible examples of such racism in contemporary Western society are less and less evident. Stereotypes of Asian Americans in popular culture have largely shifted from “menace” to “model minority,” a characterization that attributes Asian Americans to high academic and professional achievement (Ng *et. al.* 2007). Despite these important shifts, there are several themes that have persisted. First, Asian Americans continue to live on the peripheries of American “normalcy.” Second, Asian Americans, regardless of their national origins, citizenship status, or family history in the United States, are perpetual

“outsiders.” Finally, in contrast with their new role as the “model minority,” Asian Americans continue to be associated with disease.

So how does this historical pattern of Asian American racial stigmatization at all relate to public health? Some scholars argue that in the late 19th and early 20th centuries, increased Asian immigration birthed the expansion of the U.S. public health infrastructure as a way to more effectively regulate those new populations (Molina 2006, Shah 2003). Public Health departments in California, for example, acquired more resources when faced with the dilemma of regulating Chinatowns, as these areas were seen as menacing sites of filth and disease. In her study of LA Chinatowns and public health policies, Molina asserts: “Rather than addressing the structural inequality that produced the unhealthy environments that hosted virulent diseases, public health departments consistently identified the root of the problem as racialized people who were in need of reform.” In order to accomplish this “reform,” public health officials used measures of segregation or relocation, as they believed Chinese immigrants’ personal habits and cultural proclivities were to blame for their less-than-adequate living conditions. These officials concluded, “Chinese people would always be disease carriers. They were dirty by nature, they preferred to live in crowded, ramshackle housing, and they seemed incapable of either learning or practicing good hygiene” (Molina 2006). Thus, in addition to their perceived status as economic and social threats, Asian Americans also became health threats who needed to be severely regulated.

To see how public health discourse became an important tool in the public dissemination of these racialized health stigmas, it is important to fully understand *what* public health discourse means and *how* it conveys information. The overarching concept

of “discourse” refers to language that is used as social practice. Discourse is non-neutral, something that “moves back and forth between reflecting and constructing the social world” (Rogers *et. al* 2005). More specifically, “public health discourse” is constructed to cater to a particular public audience (Briggs 2003), but has a notable authority and thus power to shape the beliefs of that particular public. Public health discourse, which includes medical and public health reports, memos, statements, speeches, and press publications, is certainly used to convey important information to improve the health status of the public. However, it also has the persuasive power to shape racial meanings in a medical context through a perceived “scientific objectivity.” Thus, in the historical case of public health departments’ adamant portrayal of Asian Americans as disease-carrying outsiders, the American public quickly and easily internalized that stereotype as truth.

Public health discourse, while no longer directly pointing the finger at Asian Americans as the source of germs, works in tandem with other public discourses to perpetuate and reshape historicized stereotypes of Asian Americans through frameworks of “othering” and an imagined transnationalism. “Othering,” or the process by which a hegemonic majority identifies and marginalizes a group as different and therefore weaker, plays a strong role in the perception of Asian American identities (Said, 1978). As Molina effectively asserts, “Public health policies and discourse played an important role in shaping and promoting images of Asians... as non-normative. Even today, stereotypes of the... wily Asian vendor, and the germ-spreading Chinese launderer persist.” Imagined transnational ideologies work intimately with “othering” frameworks to perpetuate such non-normative Asian American images. Transnationalism, an ideology

that infuses cross-border activity into various socioeconomic, cultural, and political identities, can be employed discursively to ascribe an intrinsic “foreign-ness” to its subject (Vertovec, 1999). In the case of a perceived Asian American identity, public health discourses often engage an imagined transnationalism by forming direct and indirect linkages between “Asian American” and “foreign.” The discourse infers “foreign” here as not only non-normative, but also an embodiment of a perpetual outsider status.

Public health discourse on tuberculosis is a tangible example of how “othering” and imagined transnational frameworks operate to reflect, refine, and reinforce an Asian American racial identity. Asians and Asian Americans have long been discursively associated with the spread of Tuberculosis in the United States. In reference to Asian Americans, King notes in his essay on immigration and TB that “the association of infectious disease with outsiders has a long history... During the successive waves of immigration to the USA in the late nineteenth and early twentieth centuries, Americans frequently blamed immigrants for the spread of various infectious diseases” (King 2003). According to Asian American scholar Nyan Shah, in the early to mid 20th century, Chinese, and by extension, all Asian Americans, were cited as the source of the TB epidemic in San Francisco: “Chinatown [w]as the epicenter of another rampant epidemic—tuberculosis. One-fourth of all city tuberculosis cases lived in Chinatown, and Chinese residents faced a tuberculosis infection rate three times the city average in a period when overall tuberculosis infection rates had tumbled.” As Asian Americans continue to appear frequently in public health discourse on TB ranging from CDC reports to news articles, there exists a plethora of evidence to substantiate the specific ways in

which such discourse produces and reproduces racial stereotypes (Shah 2003).

Furthermore, a thorough analysis of this discourse may help to inform alternative discursive frameworks with greater public health implications.

Review of Literature

While there is an immense body of existing literature related to Asian Americans, public health discourse, and tuberculosis as disparate subject areas, there are very few scholars that link these themes together in their work. Notably, some groundbreaking research done by Molina (2006) and Shah (2001) exposes the history of Asian American stigmatization as it is related to health and health discourses. Molina (2006) examines how exclusionary policies used public health arguments to regulate the Chinese community in Los Angeles, California up until the mid-20th century. Similarly, Shah (2001) investigated how public health departments demonized the Chinese community in San Francisco, California, which paved the way for discriminatory policies. While public health discourse is largely not a central question in discussions of Asian American stigmas, both texts by Molina (2006) and Shah (2001) explicitly identify public health discourse as a racializing force in Asian American history. Their work demonstrates that public health has historically helped to construct and perpetuate racial stigmas, often with a political agenda.

The aforementioned studies have incorporated public health discourse into their arguments as a more indirect means to stigmatization through exclusion policy; however, there is a pronounced absence of direct discourse analysis. Markedly, Briggs (2003) investigates public health discourse, its language ideologies, its sociocultural effects, and

approaches to its critical analysis. Although his 2003 paper centers on a case study of public health discourse in Venezuela about cholera, it is a more recent example of how public health discourse can be a mechanism to maintain social inequality. Briggs synthesizes his work on health discourse and its analysis in his 2005 review. In his paper, the author describes how ideologies of disease communicability can translate into a discourse that both medicalizes and racializes, demonstrating how race and health intersect in these conversations. While Briggs (2003, 2005) does not concentrate on Asian Americans in his texts, his work is critical in that it names health discourses themselves as sites of cultural privilege and racialization.

Finally, there is limited but available scholarship in both the natural and social sciences on tuberculosis as it relates to Asian Americans specifically, which provides an important medical, epidemiological, and cultural context when analyzing public health discourse that implicates TB and the Asian American community. Much of the recent TB scholarship has discussed the sociocultural factors in TB infection rates in terms of global epidemic, investigating how gender, geographic location, and poverty cause certain populations to be more disproportionately infected than others (Cailhol *et al.* 2005, Gandy *et al.* 2003). In the United States, King (2003) and Ho (2004) makes the connection between various cultural, environmental, and politico-economic factors and TB infection, particularly in immigrant communities. Most if not all TB scholarship that discusses Asian American communities concentrates on the correlation between TB and Asian immigrants. In an earlier paper, Ho (2003) investigates the processes of Asian immigration (both legal and illegal) to New York City and how they can influence TB infection risk. Markel and Stern (2002), while discussing disease in general, critically

illustrate the continual association of TB and Asian immigrants. In literature that examines health disparities in Asian American communities, many scholars point to the disproportionate rates of TB infection in Asian Americans in the context of many other current health concerns (Hogue *et al.* 2000, Huff and Kline 1999, Lee 2009). Each of these works attempts to identify sociocultural, socioeconomic, and environmental factors that play into this disparate impact of TB on Asian American communities; again, providing important context for my research question, but failing to address the implications of public health discourse in light of this context.

From what I have gleaned from my secondary source research, there is no existing scholarship that directly addresses how contemporary public health discourse of tuberculosis reproduces historicized racial stigmas of Asian Americans. As notable work has already been done to research historical Asian American stigmatization and its relation to health, public health discourse and social inequalities, and tuberculosis in Asian American communities, my proposed research is the next logical step in interdisciplinary scholarship of Asian American studies and public health. In effect, my research comprehensively ties together the existing work cited above, using others findings and conclusions to substantiate my analysis. As my work very specifically examines discourse on tuberculosis and Asian Americans, I hope that it paves the way for future studies examining how public health discourse can maintain social and racial inequalities both in the United States and abroad. Methodologically, my work contributes to what I hope will be a growing trend of bringing medicine and humanities together in the same conversation to better understand the diverse ways in which racial meanings are constructed and maintained.

Research Methods and Methodologies

In my research, I sought to explore if and how public health discourse on TB contributed to the (re)construction of a perceived Asian American racial identity. When conceptualizing my methodological approach to this research question, my positionality drove the formulation of my interdisciplinary framework. On one hand, I am personally committed to social justice for marginalized communities, particularly Asian Americans and other communities of color. On the other hand, I am also academically committed to public health, a field often structurally criticized for its complicit participation in the marginalization of particular communities. I strongly believe, however, that public health is a field that not only has the ability to employ social justice ideologies, but is already charged to do so in its health disparities emphasis. I envisioned a methodological approach that would allow me to think critically about public health discourse without discounting its notable merits.

I thus selected the approach synthesized by Rogers *et al.* in their 2005 interdisciplinary review of Critical Discourse Analysis (CDA) for its ideological support in accomplishing my methodological aims. The authors assert that the CDA methodology is “an attempt to bring social theory and discourse analysis together to describe, interpret, and explain the ways in which discourse constructs, or becomes constructed by, represents, and becomes represented by the social world” (Rogers *et al.*, 366). CDA is particularly concerned with how issues of power and justice are embedded in linguistic patterns, and is thus a useful methodology for my examination of how public health discourse constructs and represents racial meaning. This methodology involves analysis at the textual level; the discursive level, referring to discourse production, interpretation,

distribution, and consumption; and the sociocultural level, referring to issues of power and how discourse operates in society.

For my research, I have conducted a critical analysis of public health discourse primary sources published within the past decade. These primary sources include reports, journal articles, and news articles published by national, county, and city-level public health departments and organizations such as the CDC, the San Francisco Department of Public Health, the Los Angeles County Department of Health, and the King County Department of Public Health. My selection of primary sources is meant to be representative of the nationwide public health discourse on TB, with a wide breadth in terms of primary source variety (i.e. news articles versus health department reports) as well as geographic location.

In my selected primary sources, I pay specific attention to how race is constructed on a textual and discursive level. My textual-level analysis involves a thorough coding and re-coding of the discourse to elicit collective trends as they relate to Asian Americans. By contrast, my discursive-level analysis relies more on support from secondary sources that investigate how and why the public may receive and interpret this discourse as well as the lived social impacts of this discourse on Asian Americans. In general, I will draw from multiple disciplines in both the natural and social sciences as support and evidence for my examination of how the current U.S. public health discourse on Tuberculosis, such as the cited CDC report, frames Asian Americans as a racial group.

An Analysis of Public Health Discourse on TB: Beyond the Epidemiological Trends

Through a critical analysis of American public health discourse on tuberculosis, I

elucidate several thematic examples of how “othering” and imagined transnational frameworks work to reflect, refine, and reinforce racial meaning in Asian Americans. Firstly, reported statistics on TB infection and epidemiology focus on categories related to race and national origin, often conflating the two through the direct association between “Asian American” and “foreign-born” categories. Secondly, there is a notable presence of “us versus them” rhetoric in this discourse through the focus on immigrant bodies and spaces, which perpetuates the imagined transnational dimension of the perceived Asian American identity. Finally, much of the discourse reflects an essentialist perspective in discussing public health explanations and solutions to the TB epidemic; that is, populations most affected by TB (Asian Americans and/or immigrants) are fundamentally different than the white majority, which puts them more at risk. In my analysis, I use specific quotations from the discourse under each of these themes to reflect the ways in which “othering” and imagined transnational frameworks discursively construct a perceived Asian American racial identity as a non-normative “other,” perpetual outsider, and disease carrier.

Population categories: “Asian American” and “foreign-born”

In public health discourse on TB, the use of the race and national origin-based population categories to describe epidemiological trends artificially assigns meaning to these categories, both as individual populations and conflated populations. Recent public health reports, news articles, and epidemiological studies identify Asian Americans and foreign-born persons as having the highest incidence of TB infection as compared to other racial and national-origin-based categories. Public health discourse not only affirms that “Asian American” and “foreign-born” are important, medically necessary categories,

but also that these categories are rarely discrete. I argue that regardless of the field's benevolent intentions when relying on statistics and categories to address health issues, the use of these categories continues to define and redefine certain groups by the health concerns that they respectively face. The constant statistical focus on "Asian Americans" in TB discourse as the most affected racial group serves to stigmatize Asian Americans as being carriers of tuberculosis. Furthermore, the constant association between "Asian American" and "foreign-born" in the transnational imaginary of public health discourse also perpetuates the stigma of Asian Americans as "outsiders."

The discursive effects of these population categories actually originated many decades ago. Even before the formalized existence of public health, race was already a central organizing principle used to make sense of social problems. As the field of public health began to develop extensively in the early 20th century, thus it follows that public health research centered on racial, ethnic, and gender divisions among the population (Shah 2001, Molina 2003). Originally, health departments implemented population statistics as part of an effort to standardize public health methods and reporting across the country. On a deeper level, however, statistics revealed major health differences between groups, allowing public health departments to identify the affected group as the cause of the health problem, thereby allowing policymakers to focus on reforming said group to alleviate the health problem (Shah 2001). Statistics, then, served as a way to place blame on certain groups for a particular health issue, thereby "naturalizing links between disease and identities" as certain groups were made to embody a particular health threat (Briggs 2005). Moreover, as population categorization and the field of public health have evolved

together, it has become nearly impossible to separate race from public health research and practice.

The use of public health statistics and population categories has thus understandably (and unquestioningly) continued into the 21st century. Epidemiologists across the globe rely on these categories as a standard of practice when conducting studies and gathering data, and other public health professionals and policymakers expect the same standard to make crucial public health decisions. While these statistics are theoretically used by medical and public health officials to better serve affected populations as opposed to reforming them, this change of intent does not mean that the use of sociocultural categories in public health statistics is any less problematic. In the case of using “Asian American” as a statistical category, for example, it is unlikely that one could accurately illustrate and then address the health concerns of all individuals who fall under that racial designation by painting with such a broad brush (Huff and Kline, 1999). Similarly, the conflation of “Asian American” and “foreign-born” is an inaccurate reflection of the diversity Asian American experiences living in the United States.

There are many examples of how these categories and their conflation produce social meaning in local and national public health discourses. In much of this discourse, race and national origin are left as separate categories with ambiguous, inferred linkages between one another. On a national scale, last year the CDC reported in its *Morbidity and Mortality Weekly Report* that:

Foreign-born persons and racial/ethnic minorities continued to have TB disease disproportionate to their respective populations. The TB rate in foreign-born persons was nearly 11 times higher than in U.S. born persons. The rates among Hispanics and blacks were approximately eight times higher than among non-Hispanic whites, and rates among Asians were nearly 26 times higher... Asians had the highest TB case rate among all racial/ethnic groups. (CDC, 2010)

The implication of these statistics is that white, U.S.-born individuals represent the healthy “standard,” while Asian Americans and foreign-born persons characteristically embody TB infection. Local public health reports and news articles either reuse these CDC statistics or use the CDC framework as a model, supplemented with their own data. An article on CNN.com, for example, employs these CDC statistics to highlight the clear TB infection disparity amongst racial and ethnic groups, particularly Asian Americans: “The latest CDC statistics highlight that racial and ethnic minorities are much more likely to get TB. For example, TB rates among Asians were 25 times higher than among whites” (Falco, 2011). The same article also cites the infection disparity among foreign-born persons: “The CDC report also notes that the majority of people who have TB in the US were born in another country. 60% of the tuberculosis cases in the United States are foreign-born” (Falco, 2011). Nation-wide epidemiological studies conducted outside of the CDC arrived at similar conclusions, as one summarizes “Foreign-born persons have accounted for >50% of all TB cases in the United States since 2001, with Asian/Pacific Islanders (APIs) representing the burden of disproportionately high TB case rates among all racial groups in the United States” (Manangan *et. al.*, 2009). On a more local level, the Los Angeles Department of Public Health also reported the high incidence of TB among Asian Americans: “The incidence rate of tuberculosis in Asians was higher than in any other racial/ethnic group (25.8 cases per 100,000)” (Los Angeles County Department of Public Health, 2005). An article in the *Los Angeles Times* again underlined the significance of these categories in discussions of local TB incidence: “Racial minorities and foreign-born people continued to be disproportionately affected by the disease. In California, there were 22.9 cases of TB for every 100,000 Asian American residents; 8.7

for blacks; and 7.6 for Latinos. The rate was 1.6 per 100,000 for whites” (Lin, 2009). In general, nearly all forms of public health discourse on TB in the U.S. featured Asian Americans and/or foreign-born persons as significant populations in discussions of TB incidence. Recalling the power of public discourse to effectively disseminate information, this discursive trend alludes to the pervasiveness of these perceived racial and national origin-based identities.

The conflation of race and national origin in public health discourse on TB is in some instances made more directly. According to many reports and news articles, there is significant overlap between “Asian American” and “foreign-born,” meaning that many of those infected belong to both categories. In fact, in 1987 the CDC reported: “In 1985, tuberculosis among Asian/Pacific Islanders occurred almost entirely among foreign-born persons” (CDC, 1987). While that report was published over 20 years ago, public health discourse has continued to follow such language that conflates the “Asian American” and “foreign-born” categories. A study on TB-related mortality in the US, for example, reported: “The majority of the TB-related deaths among Asian people... were foreign-born individuals” (Bellomy, A. *et. al.*, 2010). Similarly, the Los Angeles County Department of Public Health connects Asian Americans and foreign-born persons in its TB data: “Of 323 Asian/Pacific Islander TB cases, the majority were foreign-born (314, 96.9%)” (Los Angeles County Department of Public Health, 2005). The San Francisco Department of Public Health even lumps together Asian Americans and foreign-born persons into one category in a recent World TB Day report: “Currently our data shows that Asian newcomers bear a disproportionate burden of TB in the City” (San Francisco Department of Public Health, 2006). In such discourse, these categories of race and

national origin demonstrate significant overlap and are even reported to be one in the same. Ultimately, this conflation reaffirms Asian American as a transnational category in the public imaginary.

In contemporary public health discourse, it seems that the use of statistics and categories cannot escape its oppressive origins when highlighting health disparities. The use of race and national origin-based categories to illustrate TB infection disparities does highlight an empirical, epidemiological truth, it also serves to construct and maintain racial stigmas of Asian Americans as non-normative, disease-carrying, perpetual outsiders. Again, while these stigmas may have already been circulated and accepted in the greater public, the authoritative nature of public health discourse legitimizes and normalizes these stigmas (Briggs, 2005).

“Us versus Them” rhetoric

Another important implication of the use of statistical categories in public health discourse is how groups within one category are compared with one another, an inherent component of public health as a population-based practice. Groups that are statistically associated with certain health issues are compared against groups that are statistically less associated with those health issues, or what might be interpreted as the health “norm.” These group-defined health distinctions have the tendency to foster an “us versus them” outlook, engaging in both an “othering” and imagined transnational dialogue. Particularly in the context of U.S. public health discourse on TB, “us versus them” rhetoric appears in its focus on immigrant bodies, foreign spaces, and “global/local” syntax. The constant emphasis on immigrants, immigration, and foreign spaces infers that TB is not intrinsically associated with the United States (“us”); rather it is a problem that exists for

those falling outside of the United States (“them”). Moreover, the appearance of TB within the United States is a result of it being brought over from outlying groups, particularly from Asia. I argue that the “us versus them” rhetoric in public health discourse on TB more profoundly instills “otherness” and “foreign-ness” into Asian American racial meaning.

Immigrants have historically been blamed with bringing disease to the United States (Briggs 2005, Markel and Stern 2002). While there is epidemiological justification behind this persistent assertion, as Markel and Stern argue, the “line between perceived and actual threat is slippery and prone to hysteria and hyperbole.” Whether or not there is any truth to the fear of foreigners being disease carriers, the constant association between foreigners and disease in public health discourse contributes considerably to the anti-immigrant rhetoric that pervasively circulates in the American imaginary (King 2003). In the case of TB, the more recent disease incidence in the Western world has “reignited the persistent association between foreigners and germs” (Markel and Stern 2002). This association between immigrants and the TB epidemic has brought U.S. borders under close scrutiny, both politically and socially, resulting in a more intensely regulated border patrol as well as increased racist and nativism sentiments (King 2003, Lee S. 2009).

While “U.S. immigrant” is a very general term that encompasses those from any and all regions outside of the United States, recalling the analysis of population categories in the previous section, it is an identity very strongly associated with perceived Asian American identities in the context of Tuberculosis. Just as public health discourse often places together and conflates the population categories “Asian American” and “foreign-born,” this discourse often identifies immigrants as Asian. The *Philadelphia*

Inquirer article, for example reports of the TB epidemic: “The new arrivals most affected are Asian immigrants, health officials said yesterday...” (Fleming, 2001). The article later describes the public health department’s struggle to address the “waves of Asians arriving.” Through the constant association of Asian Americans and immigration when discussing TB incidence, public health discourse locates Asian Americans outside of the “us” category and into the “them” category. Despite the fact that many Asian Americans have lived in the United States for many generations, public health discourse reinforces the stigma of Asian Americans as perpetual outsiders, both in terms of national borders and in terms of health norms. Furthermore, as the same discourse also identifies immigrants as a public health threat by transporting TB across borders, Asian Americans bear the same “disease carrier” stigma by association in the public imaginary.

Public health’s discursive focus on infected immigrant or “foreign born” bodies is a striking example of this “us versus them” rhetoric, placing a discursive distance between healthy, domestic bodies and unhealthy foreign bodies. The 1987 CDC report on TB morbidity and mortality makes a direct, causal connection between immigrants and increased TB infection rates in the United States:

In 1980, a large influx of refugees into the United States from Southeast Asia caused national tuberculosis morbidity to increase. When the number of refugees entering the United States decreased, the national trend resumed its previous decline. (CDC, 1987)

This discourse renders immigrant and refugee bodies visible in a very specific way, a process that produces negative images of those who are normally kept invisible in the public sphere. While some may accredit such associations to the antiquated nature of the report, similar language continues to persist in more contemporary public health discourse. An article in the *Philadelphia Inquirer* quotes the Philadelphia Department of

Public Health director in saying that the American attention to Tuberculosis is “important because of the immigration trend... important because of the incidence of disease in those communities...” (Fleming, 2001). In other words, while TB may not impact the rest of the United States, it is important to stay vigilant because the disease is prevalent among U.S. immigrants. An article in *USA Today* makes a similar claim: “Tuberculosis cases continue to fall in the United States, but some immigrants have disturbingly high rates of the disease, according to a study released Tuesday that called for more aggressive action” (Tanner, 2008). This discourse applies an almost violent and policing syntax in its discussion of TB infection in immigrants, reminiscent of U.S. border patrol ideologies, using adjectives such as “disturbing” and “aggressive.” TB does not affect “us”—Americans, but the high rates of TB infection among “them”—U.S. immigrants— are disturbing enough to incite violence against the “other.”

In a similar vein, public health discourse often focuses on foreign spaces to illustrate the impact of the TB epidemic, thus employing a directly transnational framework as part of the greater “us versus them” rhetoric. Often, public health discourse identifies foreign countries or locations distinctly outside the United States as sites of TB. For example, the CNN blog article cited earlier explains:

The majority of people who have TB in the US were born in another country... some of these foreign-born people may have been infected in their home countries before coming to the U.S., or they may have traveled back to their countries of origin and been infected while visiting. People born in the United States aren't immune of course. If Americans travel to countries with high rates of TB, they can be infected just as easily. (Falco, 2011)

Here, Falco offers a transnational explanation for TB incidence in the United States that in fact places full blame on immigrants for bringing TB to *us*. Talbot *et al.* in their epidemiological study mirror this rhetoric of infected foreign spaces: “Most infections,

cases, and deaths occur in developing countries. In a number of developed countries with substantial levels of immigration, however, foreign-born persons increasingly contribute to the incidence of TB and sustain TB rates” (Talbot *et. al.*, 2000). While this language does not outwardly connect TB with foreign bodies, it more indirectly makes this connection through the implied association between foreign bodies and foreign spaces through birth. Some literature makes this connection more clear, such as Bellomy’s study on TB mortality that notes: “Differences in TB mortality were found in relation to place of birth” (Bellomy, A. *et. al.*, 2010). Los Angeles County similarly reports infection statistics in terms of place of birth: “Epidemiologic data show that about 80% of TB cases in LAC occur among those who were born outside of the U.S.” (County of Los Angeles Public Health, 2009), as does King County in Seattle: “Of the 116 people diagnosed with active TB in 2010, 84 percent were born outside the United States” (King County Department of Public Health, 2011). Again, this discourse reflects and perpetuates the idea that “we” (Americans) would not be affected by TB had it not been for “them” (immigrants and foreign countries) bringing TB into “our” country.

Another related manifestation of “us versus them” rhetoric in public health discourse is the frequent use of the terms “local” and “global,” which syntactically distinguishes the healthy local sphere from the unhealthy global sphere. Despite their possible indication of efforts to participate in a more geographically inclusive discussion, “local” and “global” appear to be euphemisms of “us” and “them.” U.S. public health discourse often points to TB as being a “global” health issue, but one that is not experienced “locally.” In other words, “they” have TB, and “we” don’t have TB. For example, the King County Department of Public Health reports that the current incidence

of TB in King County: “reflects a local symptom of a continuing global epidemic” (King County Department of Public Health, 2009). Similarly, when discussing the implications of drug-resistant TB in particular, the LAC Department of Public Health affirms that TB is an “increasing public health threat, both globally and locally here in Los Angeles County” (County of Los Angeles Public Health, 2009). Other reports use “global” to pin TB on “them,” ironically and inaccurately implying that the United States is outside of this “global” category. The same LAC public health report, for instance, postulates: “With the ever-increasing rate of international migration and travel that characterizes modern times, the U.S., and LAC in particular, will not be immune to this increasing global threat” (County of Los Angeles Public Health, 2009). Through “local/global” syntax, the report regrettably reveals that even the health and mighty “we” should feel threatened by the invasion of the diseased “them.”

Using “us versus them” rhetoric through “othering” and transnational frameworks, public health discourse on TB thus not only distances the United States from the “global” TB issue (as “we” are not the source of the problem and “they” are), but it realizes the threat of TB being brought over from a global context to a local context through immigration of foreign bodies. In this way, the added element of fear more aggressively engrains the social identities of Asian Americans as the foreign and diseased “other” in the public imaginary.

Blurring the line between correlation and causation

Perhaps one of the most significant implications of the previously elucidated rhetoric is the underlying inference of causation due to the lack of adequate data contextualization. By presenting TB incidence data through the categories of race and

national origin, often *without* a deeper socioeconomic, cultural, and political context, the public health discourse implies a causative rather than corollary relationship between those groups and TB (Plummer and Porter, 1997). That is to say, Asian Americans have a high incidence of TB *because* of their racial and national origin identities, rather than the multifaceted context in which these identities are located. Consequently, as the discourse infuses “disease carrier” with a perceived Asian American racial identity, Asian Americans come to be seen as the *cause* of the continued incidence of TB in the United States.

Social science-oriented scholars have termed this tendency towards causation “essentialism,” or the reduction of a complex social phenomenon to essential differences between people (Farmer 1999, King 2003). More specifically, health disparities like in the case of TB disproportionately affect certain populations “because they are intrinsically different in some way... biological, physiological, genetic or cultural differences cause certain people to be more or less susceptible to TB” (King 2003). Essentialism is an attractive etiological approach in public health because it delineates a distinct problem with a single cause, facilitating ease in the gathering of epidemiological data and efficiency in resource distribution through targeted interventions. On the public receiving end of the discourse, essentialism is politically appealing because it allows “pre-existing racist or nativist sentiments to be clothed in the garb of objectivity and scientific authority, and leading to victim-blaming and stigmatization of socially marginalized groups as disease ridden” (King 2003). It thus follows logically why essentialism is pervasive in public health discourse as it relates to TB; regardless of any

intention to oversimplify the issue, there are underlying pressures across many disciplines to do so.

Of course, in reality, the uneven distribution of TB infection rates across the United States has an incredibly complex socioeconomic, political, and cultural context that has yet to be fully explored. While it may be true that Asian American, immigrants, and Asian immigrants bear the epidemiological brunt of the incidence of TB in the United States, there is no scientific evidence that points to their racial or national origin identities as the single reason why this is so. However, the ways in which public health discourse on TB is constructed obscures the perhaps more accurately representative infection disparities as they relate to socioeconomic status, place of residence, access to healthcare, and institutionalization rates. Instead, the essentialist approach of public health discourse builds upon “othering” and imagined transnational frameworks to “engender a vicious cycle of stigmatization and social and economic marginalization” towards Asian Americans (King 2003).

While essentialism can be found in much of the previously analyzed citations, there are moments when it operates more overtly in public health discourse on TB. For example, in a study published in a medical journal on Tuberculosis and lung disease, the authors assert: “TB disparities may be related to place of residence, race/ethnicity, country of origin, ” continuing that, “being foreign-born was a highly associated TB risk factor (Manangan *et al.* 2009). While the authors do not explicitly point to place of residence, race/ethnicity, and country of origin as the *causes* of TB incidence, the lack of contextualization as to *why* there is a correlation may lead to a simplified interpretation of causation. Another study similarly walks the line between causation and correlation

without contextualization: “Immigration has contributed substantially to changes in TB epidemiology in the United States during the last decade and is considered an important factor in the resurgence of TB during the late 1980s and early 1990s” (Talbot *et. al.*, 2000). Again, while the authors indicate a correlation between immigration and TB incidence, without a deeper socioeconomic and political context to reveal why immigrants have higher rates of TB, immigrants appear to have high rates of TB due to their citizenship status.

Additionally, the essentialist discourse related to marginalized racial groups and immigrants in general, there are examples where public health discourse more explicitly supposes causation between Asian Americans and/or Asian immigrants and TB incidence. For instance, an article in the *San Jose Mercury News* reports: “Fenstersheib [Santa Clara County’s public health officer] attributes the uptick in cases in Santa Clara County partly to new immigrants from Southeast Asian counties such as Vietnam where tuberculosis is rampant” (Ostrov, 2007). As is true with much of the discourse, the assertion that immigrants are the cause of the region’s increase in TB cases is given no deeper context to prevent blaming TB incidence on the immigrant identity. As Ostrov implies, immigrants from Southeast Asia are the cause of TB in the United States, ignoring the complex structural factors that render TB to be “rampant” in particular communities. In general, there is a fine line between correlation and causation in public health discourse on TB, and often these two ideas are confused easily and used interchangeably in the public imaginary. This conflation becomes problematic, however, when suggested causality in public health discourse reinforces the stigma that Asian immigrants, and by association Asian Americans, are disease carriers.

Proposed solutions to the TB epidemic

Keeping in mind the larger implications of essentialism in public health discourse, it follows that the proposed strategies to defeat the TB epidemic in this discourse continue to use the “othering” and imagined transnational frameworks to reinforce the racialization of the disease and the stigmatization of Asian Americans. Much of this discourse suggests that public health efforts to expunge the disease should be focused on the populations most at risk of infection. While this charge makes good theoretical sense considering limited resources and an immense pressure to rid the world of tuberculosis for good, its identification of the “at risk” populations to target continues to infer social meaning to those groups as non-normative, outsiders, and disease carriers.

Public health’s drive to control the TB epidemic by targeting high-risk populations discursively identifies those populations as the “other.” The CDC, for example, affirms of its goal to eliminate TB that: “Achieving this goal demands targeted interventions for populations at high risk” (CDC, 2010). The King County Department of Public Health similarly suggests, “Strategies to improve program efficiencies include... focused use of resources on cases posing the greatest public health significance” (King County Department of Public Health, 2009). The County of Los Angeles Department of Public Health agrees: “Success locally and abroad can result in complacency and resurgence of disease if aggressive public health efforts to detect and treat TB in population subgroups are not maintained” (County of Los Angeles Public Health, 2009), reusing the almost violent syntax of “aggressive” action to control TB in “population subgroups.”

As the discourse largely identifies Asian Americans as the source of TB in the United States, it is intuitively clear that those “at risk populations” to target are in fact Asian Americans and Asian immigrants. The study by Manangan *et al.* makes this connection explicitly: “The findings highlight the need to target services for foreign born API TB patients” (Manangan *et. al.*, 2009). The conclusion to focus TB control efforts on Asian Americans, the population that the discourse has identified as the most impacted and most at risk, makes logical sense. This call to action, being that its primary focus is Asian Americans, suggests that TB need not be addressed outside this population. In excluding Asian Americans from the healthy majority, the public health discourse is thus reinforcing this racial group as the “other” (Said 1978, King 2003). The rest of “us” are much less at risk and not affected; the problem lies outside with “them.” Following the rhetorical cues elucidated through textual and discursive analyses of public health discourse, even the discourse’s epidemiological strategies force Asian Americans outside the peripheries of normalcy.

Conclusion

While the intention behind the production of public health discourse is not always clear, using the methodological approach proposed for a critical discourse analysis can reveal important trends related to the social construction of identities. Particularly in light of the coevolution of racial meanings and the field of public health, Tuberculosis is a useful example of how health disparities can discursively be translated the racialization of a disease and the stigmatization of the disproportionately affected racial groups. It is important to note that the objective of conducting a critical analysis of public health

discourse is not to dispute the health disparities that it conveys. There is indeed a significant amount of medical and epidemiological evidence that Asian Americans have a proportionally higher rate of TB infection than any other racial group in the United States. The point, then, of conducting a critical analysis of public health discourse on TB is to examine *how* this disparity is presented and to postulate how this discourse may be informing both the ways in which the public conceptualizes the Asian American identity as well as how those identified as Asian American experience their identities in society.

Manifestations of the stigma

With regard to the former objective, I have shown that the use of statistical categories, “us versus them rhetoric,” essentialist approaches, and targeted epidemiological strategies contribute significantly to the construction of Asian Americans as a racial group through the frameworks of “othering” and an imagined transnationalism. As social and political structural forces have stigmatized Asian Americans as non-normative disease carriers and perpetual outsiders since the first wave of Asian immigrants centuries ago, I have shown that contemporary public health discourse on Tuberculosis reflects, reframes, and perpetuates these historicized stigmas. Regarding the latter objective, however, tangible manifestations of these stigmas are difficult to uncover. Unlike the overt racism demonstrated by the exclusionary immigration and public health policies of the 19th and early 20th centuries, racial stigmatization of and discrimination towards Asian Americans today has evolved under the pressures of political correctness to be less explicit. Anthropologist S.J.C. Lee contends: “Overt acts of racism are uniformly condemned and entitled to redress, but people are less willing to concede the perpetuation of systemic discrimination, in part because it suggests tacit

approval of selective privileges we prefer to cast as individual merit” (Lee S. 2009). If this systemic discrimination still pervades in society today, then where is it?

A perfect example of contemporary experiences of discrimination against Asian Americans as they relate to infectious disease is the severe acute respiratory syndrome (SARS) outbreak in 2003 and its social ramifications. SARS, also known as the Asian flu, began as a sudden outbreak in Hong Kong and quickly spread to dozens of other countries, including the United States. Like Tuberculosis, SARS had very strong associations with Asians and Asian Americans, and the fear and hysteria related to the epidemic resulted in widespread discrimination of Asian Americans. An essay from a CDC-based journal reports: “During the SARS outbreak, some persons became fearful or suspicious of all people who looked Asian, regardless of their nationality or actual risk factors for SARS, and expected them to be quarantined” (Person *et al.* 2004). Many Asian Americans reported receiving negative treatment and being ostracized. The CDC reports also that stigmatization of Asian Americans during the SARS epidemic may very well have become a vicious cycle:

Fear of being socially marginalized and stigmatized as a result of a disease outbreak may cause people to deny early clinical symptoms and may contribute to their failure to seek timely medical care. Such fear can ultimately increase stigmatization when cases are identified at a later date. (CDC 2004)

There is little scholarship that explores how and if Asian Americans have experienced social consequences of Tuberculosis and the discourse surrounding the epidemic, but it is easy to draw parallels between the two scenarios. Perhaps the stigma created by the SARS epidemic was more pronounced due to an elevated fear of its spread, but as Asian Americans were at the center of each epidemic, it is likely that Asian Americans experience some level of discrimination and ostracizing today as a result of Tuberculosis.

Some scholars even argue that the tuberculosis epidemic and the discourse surrounding it has incited anti-immigrant political mobilization, specifically targeting Asian immigrants. In his essay “Immigration, Race and Geographies of Difference in the Tuberculosis Pandemic,” King argues that the reception and support of essentialist approaches to TB control: “has led public health officials to recommend a range of responses, from better policing of national borders and tighter controls on legal and especially illegal immigration, to better screening and treatment of the people crossing those borders” (King 2003). King then directly links public health discourse to anti-immigrant political mobilization when citing a 1994 report from the *Journal of the American Medical Association* that claimed that foreign-born persons were responsible for 60 percent of TB in the United States: “[this assertion] attracted the interest of anti-immigration groups such as the Federation for American Immigration Reform, which invoked the threat of tubercular immigrants as justification for cracking down on legal and illegal immigration” (King 2003). Again, as I have shown how “Asian American” and “foreign-born” or “immigrant” are often conflated identities, it is clear that public health discourse on tuberculosis could potentially have political ramifications for Asian Americans in addition to social ones.

Is the public health benefit worth the stigma?

To return to one of my original research questions, do the public health benefits of the discourse outweigh these social and political costs? S.J.C. Lee struggles with this question, noting that while public health reports that focus on health disparities are crucial for “targeting research and intervention resource allocation, the paradigm also constrains the science of health disparities research” as it becomes difficult to move

beyond a causal relationship between difference and health (Lee, S. 2004). King agrees that the discourse and its construction must be “deployed cautiously” as focusing on difference “brings risks as well as rewards. The historical record indicates that essentialist understandings of difference have played a role in the institution of some of the more pernicious nationalist and racist social policies during human history” (King 2003).

While both scholars see major problems with the way that public health discourse on TB operates, neither scholar argues decisively that the discourse should be radically changed or done away with.

Building upon the existing cost-benefit analysis conversation, it is worthy to note that despite public health’s targeted attempts to eliminate TB from the United States and the rest of the globe, the epidemic is still pervasive today in these targeted populations (CDC, 2010). It may not be too off base to wonder, then, whether or not targeting these populations truly improves health outcomes. If there were a way to reframe and redirect the discourse in a way that did not result in social and political costs for Asian Americans and *also* improved the health outcomes of this racial group with regard to TB, would that not be a much better alternative? I argue that such an alternative framework could be employed in a way that both minimizes social and political costs and maximizes public health benefits.

Changing the discourse

Firstly, if the field of public health was to continue to work with population-based statistical categories such as race and national-origin, public health discourse would need to further contextualize its statistics. There is little current acknowledgement of the complex socioeconomic, political, and cultural contexts that locate epidemiological

statistics in discourse on TB. It is important to remember that the cause of TB is the bacterium *Mycobacterium tuberculosis*, not the individuals who are infected.

Furthermore, there are two primary conditions required for an individual to acquire TB:

1) direct exposure to the airborne bacterium, and 2) pre-existing weakened immune system. An individual's likelihood to have both of those conditions is entirely based on circumstances such as living and working conditions, access to medical care and other necessities, stress, and existing compromising infections. While these circumstances may be related to racial and national origin categories due to systemic social inequalities, infection is more directly related to socioeconomic status and other structural factors.

Scholars across many disciplines have explored misconceptions about Asian Americans and immigration in public health discourse's etiological explanations of TB. Huff and Kline argue that the disproportionate incidence of TB in Asian Americans is partly due to healthcare access. "Access and barriers to health care for Asian Americans... focus on socioeconomic factors such as availability of health insurance, access and location of health care facilities, transportation, poverty, and unemployment" (Huff and Kline, 1999). Ethnic studies scholar Ho echoes the importance of socioeconomic factors as the source of TB incidence in Asian Americans: "In contrast to the explanation of public health workers... patient informants discuss at length how living and working conditions in New York City contributed to their contracting tuberculosis" (Ho 2004). In terms of immigration, Ho also argues that the migration process, particularly illegal immigration, severely weakens the immune system leaving immigrants more susceptible to TB infection. Huff and Kline agree, adding that immigrants continue to experience debilitating stress well after their arrival:

Immigration causes a number of adjustment and acculturation stresses that are related to overall health. People who were forced to leave their homes faced political exile and separation from family... Language adjustment was another stress that had to be overcome to function in a new country... (Huff and Kline, 1999)

King synthesizes this holistic perspective and argues that it is in fact inaccurate to blame Asian Americans and Asian immigrants for transporting TB from their home countries to the United States: “If TB is the result of a number of contingent causes, then disparities according to race, ethnicity or place of birth may be more closely associated with the present social or economic conditions of a group than with some essential biological or cultural difference” (King 2003). Race and ethnicity, as Lee argues, are markers of “social groups that experience disparities in health status and disease burden—disparities that result from both economic and cultural injustices... race itself is not a causal mechanism, though it is often a marker for causal pathways” (Lee S. 2004). It is extremely important to make such distinctions in public health discourse to prevent causal associations between race/national origin and TB, thereby avoiding the harmful stigmatization of Asian Americans and the consequential social and political costs.

None of this criticism is to say that there are no existing examples of positive public health discourse that effectively contextualize statistical data on TB incidence and avoid the processes of racialization and racial stigmatization. For instance, the study by Bellomy *et al.* adds after a discussion of racial disparities in TB infection: “Socioeconomic status, specifically poverty and disparities in access to health care, may also explain the differences, especially concerning the need for urgent clinical management of fulminant TB disease” (Bellomy *et al.* 2010). Similarly, the San Francisco Department of Public Health also contextualizes the racial disparity: “Although

TB can infect anyone, social disparities make it a disease of poverty, crowding and migration, affecting the most vulnerable among us first” (San Francisco Department of Public Health, 2006). While there are more examples of problematic than productive public health discourse on TB, these instances are important in illustrating the ease of which such discursive changes can be made with the addition of one or two sentences.

In the ideal world of public discourse, however, it would perhaps be most productive to completely reframe the way public health discourse on TB is constructed with new statistical categories that encompass socioeconomic and other structural factors. Briggs, whose primary academic focus is public discourse, strongly supports the idea of radical change in discourse that has harmful social and political costs: “Unless we transform ideological constructions of how knowledge is produced... we will be unlikely to promote effective alternative formulations or effectively support efforts by oppressed and marginalized people” (Briggs 2005). In terms of public health discourse, King argues that more useful population-based categories would be related to the “ways in which contingent factors—such as social and economic justice—are mapped onto difference in morbidity and mortality” (King 2003). Markel and Stern agree and argue against the use of racial and ethnic categories in public health: “If any concept in this brief history of... public health is antiquated, it is the idea that infectious disease can be controlled by targeting certain populations based on apparent ethnic or national background” (Markel and Stern 2002). Perhaps if TB statistics were based on income level, poverty, employment, access to healthcare, drug-use, and/or housing, public health discourse would be able to more accurately reflect the epidemiological breakdown of the disease as well as the causal factors. From this modified discourse, the field would likely be able to

work towards a more effective TB control program with limited social and political costs to Asian Americans and other marginalized groups.

Future research

As there is significant potential for change in the way the public health discourse on TB approaches infection disparities, it thus follows that there is substantial room for future research exploring this alternative discursive avenues. If such changes were to occur, it would be crucial for the field of public health to begin collecting data related to the newly structured categories related to socioeconomic status. As Lee asserts: “The next wave of investigation in health disparities must be about causation, where the categories of race and ethnic are only superficial markers of more complex interactions” (Lee SJC 66). This transition would likely not occur easily or willingly, but it might be useful to begin in a public health department such as San Francisco County’s, which already produces discourse that is cognizant of the underlying complex of causal issues.

Revised research methodology is also a particularly salient concern in ensuring that discursive patterns of racial identity construction do not continue. For tuberculosis research to occur in the most comprehensive and socially just manner, it will be important for public health to draw from multiple disciplines, especially the social sciences, which have historically been marginalized in the context of public health research (Lienhardt *et al* 2006). Another significant contribution to such research would be the involvement of marginalized groups in more community-based participatory research. Briggs presents a valuable perspective on this issue:

Such involvement is not only crucial for rooting out stigmatizing images but also for uprooting the hierarchical relations created by placing the people who face the worst health conditions as the final link on a projected information chain.

...inviting popular participation in shaping how health-related public discourse is disseminate should form part of efforts to break the hold of hegemonic models and practices..." (Briggs 2003).

Many disciplines, such as anthropology and sociology, already engage frequently in this kind of methodology, a fact that further encourages engagement between public health and other disciplines. While these methodological modifications would likely increase the epidemiological and social effectiveness of TB research in marginalized communities, they also have the great potential to apply to larger public health questions about health disparities in other forms of illness.

While my research has been largely critical of how public health discourses frame their data and operate in society, I would like to reiterate my devotion to the field of public health and my immense faith in its ability to eliminate health disparities worldwide. During my graduate education and career in public health, I would like to continue and expand upon this interdisciplinary work in hopes of inciting a change in the standard framework of health disparity discourse and research.

Works cited

- Bellomy, A. et al. 2010. Trends in Tuberculosis Mortality in the United States, 1990-2006: A Population-Based Case-Control Study. *Public Health Reports*. **125**(3): 389-397.
- Briggs. C. L. 2005. Communicability, Racial Discourse, and Disease. *Annual Review of Anthropology*. **34**:269-291.
- Briggs, C. L. 2003. Why Nation-States and Journalists Can't Teach People to Be Healthy: Power and Pragmatic Miscalculation in Public Discourses on Health. *Medical Anthropology Quarterly*. **17**(3):287-321.
- Bueler, J.W., D.F. Stroup, D.N. Klaucke, R.L. Berkelman. 1989. The Reporting of Race and Ethnicity in the National Notifiable Diseases Surveillance System. *Public Health Reports*. **104**(5):457-465.
- Cailhol, J., B. Decludt, and Didier Che. 2005. Sociodemographic factors that contribute to the development of extrapulmonary tuberculosis were identified. *Journal of Clinical Epidemiology*. **58**:1066-1071.
- Centers for Disease Control. 2010. Decrease in Reported Tuberculosis Cases—United States, 2009. *Morbidity and Mortality Weekly Report*. **59**(10):289-317.
- Centers for Disease Control. 1987. Topics in Minority Health, Tuberculosis Among Asians/Pacific Islanders—United States, 1985. *Morbidity and Mortality Weekly Report*. **36**(21):331-334.
- Centers for Disease Control. 2011. "Trends in Tuberculosis—United States, 2010." *Morbidity and Mortality Weekly Report*. **60**(11):333-337.
- County of Los Angeles Public Health. March 2009. "Drug-resistant TB." *The Public's Health*. 9(3).
- Dievler, Anne. 1997. Fighting Tuberculosis in the 1990s: How Effective is Planning in Policy Making? *Journal of Public Health Policy*. **18**(2):167-187.
- Falco, Miriam. March 2011. "CDC reports lowest TB rates ever in U.S." CNN.com Blogs. <<http://thechart.blogs.cnn.com/2011/03/24/cdc-reports-lowest-tb-rates-ever-in-u-s/?iref=allsearch>>.
- Farmer, Paul. *Infections and Inequalities: the modern plagues*. Berkeley and Los Angeles, CA: University of California Press, Ltd. 1999.
- Fleming, Leonard N. March 25, 2001. "Rising TB in Asians Causes Concern." *Philadelphia Inquirer*. <<http://infoweb.newsbank.com/iw->

search/we/InfoWeb?p_product=NewsBank&p_theme=aggregated5&p_action=doc&p_docid=0EB7374E09A8B564&p_docnum=1&p_queryname=1>.

Ho, Ming-Jung. 2003. Migratory Journeys and Tuberculosis Risk. *Medical Anthropology Quarterly*. 17(4): 442-458.

Ho, Ming-Jung. 2004. Sociocultural aspects of tuberculosis: a literature review and a case study of immigrant tuberculosis. *Social Science & Medicine*. 59:753-762.

Hogue, Carol J.R., Martha A. Hargraves, and Karen Scott Collins. *Minority Health in America*. Baltimore, MD: The Johns Hopkins University Press, 2000.

Huff, Robert M. and Michael V. Kline. *Promoting Health in Multicultural Populations: A Handbook for Practitioners*. Thousand Oaks, CA: Sage Publications, Inc., 1999.

King, Nicholas B. "Immigration, Race and Geographies of Difference in the Tuberculosis Pandemic." From Gandy, Matthew and Zumla Alimuddin. *The Return of the White Plague*. UK: Verso, 2003.

King County Department of Public Health. 2011. "Local TB challenges mark World TB Day." King County Department of Public Health. <<http://www.kingcounty.gov/healthservices/health/news/2011/11032401.aspx>>.

King County Department of Public Health. 2009. "Tuberculosis Remains health threat in King County." King County Department of Public Health. <<http://www.kingcounty.gov/healthservices/health/news/2009/09111701.aspx>>.

Lee, E. 2007. The "Yellow Peril" and Asian Exclusion in the Americas. *Pacific Historical Review*. 76(4):537-562.

Lee, S.J.C. 2009. Science, Surveillance, and the Politics of Redress in Health Disparities Research. *Race/Ethnicity: Multidisciplinary Global Contexts*. 3(1):51-74.

Lienhardt, Christian, Jessica Ogden and Oumou Sow. "Rethinking the Social Context of Illness: Interdisciplinary Approaches to Tuberculosis Control." From Gandy, Matthew and Zumla Alimuddin. *The Return of the White Plague*. UK: Verso, 2003.

Lin, Rong-Gong II. March 22, 2009. "California tuberculosis rate lowest on record." Los Angeles Times. <<http://articles.latimes.com/2009/mar/22/local/me-tb22>>.

Los Angeles County Department of Public Health. 2005. "Asian/Pacific Islander Tuberculosis Cases." Los Angeles County Department of Public Health Tuberculosis Control Program.

- Manangan, L. K. Elmore, B. Lewiz, R. Pratt, L. Armstrong, J. Davidson, S. Santibanez, A. Heetderks, V. Robison, V. Lee, and T. Navin. 2009. "Disparities in tuberculosis between Asian/Pacific Islanders and Non-Hispanic Whites, United States, 1993-2006." *The International Journal of Tuberculosis and Lung Disease*. **13**(9):1077-1085.
- Markel, H. and A.M. Stern. 2002. The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society. *The Milbank Quarterly*. **80**(4):757-788.
- Molina, Natalia. *Fit to Be Citizens?* CA: University of California Press, 2006.
- Ng, J.C., S.S. Lee, and Y.K. Pak. 2007. "Contesting the Model Minority and Perpetual Foreigner Stereotypes: A Critical Review of Literature on Asian Americans in Education." *Review of Research in Education*. **31**:95-130.
- Omi M, Winant H. *Racial Formation in the United States: From the 1960s to the 1990s*. New York: Roudedge, 1986.
- Ostrov, Barbara. March 20, 2007. "TB Cases on Rise in Santa Clara County – Boost in Rate Prompts Effort to Contain Contagious Lung Disease." *San Jose Mercury News*. <http://infoweb.newsbank.com/iw-search/we/InfoWeb?p_product=NewsBank&p_theme=aggregated5&p_action=doc&p_docid=11803B9AA4F388A0&p_docnum=1&p_queryname=2>.
- Person, B., F. Sy, K. Holton, B. Govert, A. Liang, B. Garza, D. Gould, M. Hickson, M. McDonald, C. Meijer, J. Smith, L. Veto, W. Williams, L. Zauderer and the NCIDSARS Community Outreach team. Feb. 2004. "Fear and Stigma: The Epidemic within the SARS." *CDC Emerging Infectious Diseases Journal*: 2004 SARS Edition. 10:2. <http://wwwnc.cdc.gov/eid/article/10/2/03-0750_article.htm#sars-relatedfear,stigmatization,anddiscrimination>.
- Plummer D and Porter D. "The use and misuse of epidemiological categories." In: Linge G, Porter D. *No place for borders: the HIV/AIDS epidemic and development in Asia and the Pacific*. New York, St Martin's Press, 1997: 41–49.
- Rogers, R., E. Malancharuvil-Berkes, M. Mosley, D. Hui, and G.O. Joseph. 2005. Critical Discourse Analysis in Education: A Review of the Literature. *Review of Educational Research*. **75**(3):365-416.
- Rosenberg, Charles E. and Janet Golden. *Framing Disease: Studies in Cultural History*. USA: Rutgers, The State University, 1992.
- Said, Edward. *Orientalism*. USA: Random House, Inc., 1978.
- San Francisco Department of Public Health. 2006. "World TB Day: City Reports Record

Low for TB Cases.” San Francisco Department of Public Health.
<<http://www.sfdph.org/dph/files/newsMediadocs/2006PR/PR03222006.pdf>>.

Shah, Nayan. *Contagious Divides*. CA: University of California Press, 2001.

Talbot, E.A., M. Moore, E. McCray, and N.J. Binkin. 2000. Tuberculosis Among Foreign-Born Persons in the United States, 1993-1998. *JAMA*. **284**:2894-2900.

Tanner, Lindsey. July 23, 2008. “Foreign-born TB cases need better control, US says.” USA Today. <http://www.usatoday.com/news/topstories/2008-07-22-335302292_x.htm>.

Vertovec, Steven. 1999. “Conceiving and researching transnationalism.” *Ethnic and Racial Studies*. 22:2 (447-462).

Zane, Nolan W.S., David T. Takeuchi, and Kathleen N.J. Young. *Confronting Critical Health Issues of Asian and Pacific Islander Americans*. Thousand Oaks, CA: Sage Publications, Inc., 1994.